STATE OF WEST VIRGINIA
THIRTEENTH JUDICIAL CIRCUIT
OFFICE OF THE COURT MONITOR

Report on Discharge Planning and Informal Recommendations

E.H.,et al., v. Khan Matin, et al.

June 22, 2012

INTRODUCTION

Plaintiffs in the E.H., et al, v. Matin, et. Al., case filed a Request for Resolution (Civil Action No. 81-MISC-585) with the Office of the Court Monitor on April 5, 2012. The Request for Resolution (RFR) alleges that:

1. Appropriate and proactive discharge planning is an essential component of treatment at the state inpatient psychiatric facilities and is necessary to ensure placement in the least restrictive setting possible.
2. There have been several reports that discharge planning for certain patients is inadequate.
3. Specifically, upon information and belief, discharge planning is not occurring adequately for the following patients:
    a. Patients with DHHR guardians;
    b. Patients who are committed through the forensic process;
    c. Patients located in diversion hospitals; and
    d. Long-term or difficult to place patients.

Petitioners requested that the Court Monitor conduct a review of the discharge planning at the state psychiatric facilities and recommend an appropriate remedy to ensure complete protection of patient's rights. Petitioners cite 64CSR59, 5.5, which states that "the client has the right to access treatment in the least

restrictive setting. The goal of treatment for a client shall be to address needs so as to permit the client to be in the least restrictive setting".

Coincidentally, in April of 2012, the Special Assistant had completed an informal report on discharge planning, focusing on the diversion facilities (those hospitals used in lieu of hospitalization at William R Sharpe and Mildred M Bateman Hospitals for civil commitment). That report can be obtained from the Office of the Court Monitor.

ACTIVITIES OF INVESTIGATION

The Special Assistant was assigned to investigate the allegations of the Plaintiffs. Her activities were as follows:

1. Advocates from both state operated psychiatric facilities were asked to identify patients they believed to be held in the hospital due to inadequate discharge planning;
2. Plaintiffs were asked to clarify the nature of the inadequacies of discharge planning;

3. Bureau for Behavioral Health and Health Facilities data was combed for incidences of patients in both state operated and privately operated hospitals held longer than 30 days;
4. The majority of the most frequently utilized private hospitals were visited in person and staff responsible for discharge planning were interviewed;
5. Private hospitals were requested to complete an Excel data base with questions regarding patients in their facilities held longer than 30 days;
6. Medical records of patients in the state operated facilities were reviewed for all patients in the hospital over two years and all patients referred by the social work staff and by the advocates;
7. The Special Assistant met with the Social Work staff of Sharpe and Bateman hospitals;
8. The Special Assistant met with the discharge planning directors of Prestera Mental Health Center; and
9. The Special Assistant reviewed the response provided by Ms. Wendy Elswick on behalf of her client the BHHF, regarding in particular, discharge planning for forensic patients in the state hospital system.

In addition, some follow-up interviews were conducted based on information provided during the course of the investigation.

RESULTS

The week of April 10 to April 17, 2012 was utilized as a reference week.

In that week, there were 29 patients in a diversion hospital (a private hospital utilized for civil commitments) over 30 days of a total number of diverted patients of 107 (about 27%). The Special Assistant requested specific information on each of the consumers in a diversion facility. By the time the questionnaires were returned a few days later more than half of the 29 patients had been discharged (several had been transferred to Sharpe or Bateman Hospital). Nonetheless information was provided on all 29 consumers as requested.

Two were elderly dementia patients placed on the geriatric/psychiatric unit at Fairmont General Hospital. Of the remaining 27, 11 were Prestera consumers at St Mary's Medical Center or Riverpark Hospital, however the number is not unusual given Prestera's enormous catchment area. Remaining consumers were from scattered geographic areas across the state with no particular Center involved.

Almost all consumers were still in the hospital due to placement difficulties caused by medical fragility in combination with behavioral issues; a history of sexual offending; on-going severe psychiatric illness; and/or homelessness without established disability income. At least two were still in the hospital because they

remained psychotic due to refusing medications and other offered treatment. Hospitals will not force treatment upon patients unless they become acutely dangerous to themselves or other patients/staff.

During the time period, the following was also discovered:

- Sharpe Hospital had 62 non-forensic patients. (The hospital's licensed capacity is 150). Twenty-eight (45%) of the 62 had been in the hospital less than 30 days. Five had not been out of the hospital in two years or more as described below. This figure represents about 14% of the patients in the hospital over 30 days.

- Bateman Hospital had 87 non-forensic patients during the reference period. (The hospital's licensed capacity is 110). Twenty nine of the patients had been in the hospital less than 30 days (33%). Eleven had not been out of the hospital in two years or more (representing about 19% of patients in the hospital over 30 days).

There were five patients at Sharpe who had not been placed out of the hospital in two years or more. All were intellectually disabled (although one was questionably so). Of the five:

- Three had DHHR guardians, only one had no guardian.

- Four had documented recent acts of aggression;

- One had documented recent acts of self-injurious behavior and pica;

- At least two are Medley class consumers;

- At least three had previously failed supervised placements due to aggression and volatility; and

- Several had been committed from Raleigh County after failed placements in Mullens Manor, an Assisted Living Facility utilized frequently as a discharge alternative from both state facilities, and were not actually Raleigh county residents although they were classified as such upon readmission.

During that week, Bateman Hospital had eleven patients who had been hospitalized for two years without placement. Of the eleven:

- Six were intellectually disabled and two of the six are Title XIX waiver clients;

- Three suffer from unremitting severe psychosis;

- Two had dementia;

- Four had DHHR guardians;

- One had a DHHR Health Care Surrogate but clearly needs a guardian;
- Only three had no guardian;
- One is a voluntary patient;
- Two refused discharge and three refused placements they had been offered;
- At least six have a history of failed supervised placements due to aggression and in fact one had reportedly raped a staff person in a community placement;
- Two will require nursing home level of care due to fragile health (This is an increasing problem according to Bateman staff);
- Two have documented histories of self-injurious behavior including pica;
- Six have documented histories of recent aggression; and
- Three have a recent documented history of sexual acting out.

CONCLUSIONS

1. Discharge planning is an integral aspect of hospital activities, whether the hospital is private or state-operated.

2. A minority of non-forensic patients end up staying for long periods of time in any facility for one of three reasons:
    a. The patient has a persistent and severe mental illness that is slow to stabilize and sometimes does not fully stabilize. As a result the patient represents a danger to himself if unsupervised but supervised placement is often refused by the patient;
    b. Placement options for patients requiring intensive intervention for violent or self-injurious behavior and for patients requiring skilled nursing care are rare and often unsuccessful; and
    c. A few patients are unable to remain in the community due to exhibiting behavior that ensures their re-institutionalization or continued institutionalization. This behavior does not appear to be the consequence of an Axis I illness. Examples would be intellectual disabilities and personality disorders, both unlikely to respond to traditional inpatient treatment in any meaningful way.

3. Physicians in state facilities sometimes describe a patient as having reached "maximum benefit of hospitalization" and hospital staff feel pressured to pursue discharge plans without considering the patient's potential dangerousness to himself or others outside the hospital due to continued albeit stable psychopathology. The expectations of some hospital staff that community based providers should be able to control violent or self-injurious patients in a community setting may be unreasonable given reimbursement limitations and difficulties in hiring adequate numbers and quality of available staff.

4. Patients needing nursing home level of care are steadily increasing in number. This strains hospital medical resources and creates significant problems in finding discharge options. Quite a few patients have been discharged from community nursing homes for behavioral or psychiatric difficulties and readmission was refused. Many, if not most, nursing homes refuse to accept patients with behavioral difficulties. These individuals spend extended periods of time in the state psychiatric facilities.

5. While some community mental health centers participate in discharge planning activities actively and productively, others have difficulty retaining linkage staff and are reluctant to pay the mileage to reimburse staff for traveling across the state for a staffing on one patient. The method that a hospital utilizes to schedule staffings has an impact on Center participation. For example, at Bateman, all staffings are held in a relatively unpredictable rotation (although the date is specified in advance, the time of the staffing for a particular patient is much more unpredictable which makes telephone participation by linkage workers difficult). Ironically, Centers with numerous patients in the hospital are more likely to profit from face to face participation of linkage workers in staffings than those with only a few, as the activity is more cost-efficient. During a recent week, Logan Mingo Mental Health Center had only four patients in Bateman Hospital and Southern Highlands Mental Health Center had ten. All of the remaining non-forensic Bateman patients are Prestera consumers and Prestera therefore is able to attend almost all staffings in person because it is cost-effective to do so. Sharpe patients during the reference week were not from any particular county of origin although Ohio and Wood counties were proportionally represented due to their larger population base. Sharpe, therefore, has to deal with the remaining nine Comprehensive Centers spread across the state, and

coordination of staffings is challenging, even though the hospital uses a systematized scheduling system.

6. Both hospitals complained that some Centers were not helpful in locating housing in the patient's home community or in transporting consumers to their initial appointments. The hospitals have consistent problems with some Centers in obtaining medication management appointments for new patients or those who had been in the hospital for long enough that their Center case was closed. A few Centers have gone to "walk in" clinic appointments for discharged patients but the times are inconvenient (for example 8 AM on Friday morning) or transportation is not provided to the appointment. Hospitals report that intake appointments are not a problem in any Center but medication management appointments are often more difficult to obtain, creating massive problems for patients who run out of medications before their scheduled appointment.

7. DHHR guardians vary in their accessibility and helpfulness. Some guardians are very responsive and involved in the cases of protected adult patients, others do not return phone calls and are not involved to any degree in patient treatment and placement. The same is true of family members appointed as

guardians or Health Care Surrogates. Use of Health Care Surrogates, while more accessible due to the simplified process for appointment, often does not adequately meet the needs of the consumer.

8. The forensic discharge planning process is exhaustive. While a few social workers may not apply for benefits sufficiently in advance for some patients, in general when a forensic patient becomes eligible for discharge, extensive discharge planning occurs. Again, some patients are extremely challenging for placement (for example, sex offenders with intellectual disabilities).

9. Recent amendments in procedures by Social Security require that the individual on SSI be actually discharged from a hospital before benefit application can be made. This creates massive problems for social workers in attempting to locate placements for patients who have no income and in many cases may not be approved for benefits for up to a year.

10. The Social Security Administration and even homeless shelters now require identification cards for individuals without driver's licenses applying for benefits and temporary shelter. Identification cards require the same documentation as do driver's licenses under recent federal security

legislation. Social workers spend untold hours rounding up the necessary documents including birth certificates, social security cards, and so forth. Lack of a guardian authorized to sign permissions complicates this task.

While this summary of issues may make the picture seem dismal, staff in the community and in the hospitals is working diligently to obtain placements for patients who are truly ready for discharge and to sustain them in the community.

There does not appear to be a consistent pattern of problems that could be addressed through wide-ranging intervention, although there are pockets of problems throughout the system. Each Center has a different relationship with each psychiatric facility and that relationship presents a different challenge from one Center to another. There are no global, systemic problems, but rather, local and idiosyncratic problems.

In general, state operated psychiatric facilities attempt to work closely with the Centers from their region, with mixed success. The diversion hospitals vary in their relationship with Centers. Hospitals that deal with one or two Centers tend to have a closer working relationship than hospitals that deal with a wider variety of Centers.

Diversion hospitals have been required to make an adjustment over recent years from dealing with voluntary, milder, more acute cases of patients with intact

homes and support systems, to much more difficult civilly committed patients with fewer available resources and greater needs. Some diversion hospitals have made the adjustment more easily than others. Those who successfully adjusted tend to have closer working relationships with Centers in their areas. Nonetheless disconnects in discharge planning for medication management and housing continue to occur at times but not with any consistency.

INFORMAL RECOMMENDATIONS

1. Regular coordination meetings between state operated hospital social work staff and supervisory staff of each Center would help to solve problems even if the meetings only occurred twice a year. This should be done Center by Center rather than all in a group in order to tease out and resolve unique problems with each Center and its relationship to the hospital. Problems in obtaining medications for discharged patients should be among the first items discussed.

2. BHHF should carefully monitor the relationship of diversion hospitals to the Centers from geographic areas that they serve most frequently. Centers (and

DHHR guardians as appropriate) should be available to assist discharge planners in hospitals to locate housing, transportation and resources for patients with such needs.

3. The Bureau for Children and Families has already created a task force of individuals working on guardianship concerns. Hopefully this will result in some creative solutions to problems and some conformity in policy implementation across DHHR area offices, resulting in solution of problems in the system.

4. Bateman could explore creation of a skilled care unit for Medicare patients within the hospital. While the hospital could receive skilled care reimbursement for only 90 days per patient, this may be of some assistance with the more complex medical patients.

SUMMARY

It is time for the Parties in the Hartley matter to have a philosophical discussion about allocation of limited resources. At present, the system is over-burdened with young, active individuals with substance abuse issues and occasionally, co-occurring psychiatric illness. While these individuals do not take up beds for long periods of time, they tend to be frequently readmitted, sometimes several times a year. Most of the Hartley class funding to date has been designated for patients with a long history of mental illness and a need for supervised or semi-supervised placement. Patients who have been in the hospital for long periods of time and who can be easily maintained in the community have become a rarity. The remaining patients are extremely difficult and expensive to maintain in community settings and are often risk management issues for community providers.

As managers of a system, it is our responsibility to allocate resources effectively and efficiently. Perhaps it is time for the focus to shift to individuals and families struggling with substance dependence. Regional short term addiction stabilization centers should represent a much more cost effective and popular alternative to institutionalization in acute care hospitals and may be the purpose to

which future Hartley funding is directed or current funding re-directed as it becomes available.

As always, the Office of the Court Monitor thanks all the individuals who made their time available to answer questions and provide verbal and written information.

Sheila Emerson Kelly, Principal Investigator

June 22, 2012

David G. Sudbeck, Court Monitor

June 22, 2012